

CHILD FATALITY REVIEW PANELS

This attachment provides information regarding the Child Fatality Review Panels (CFRP's).

1. The prosecuting attorney in each county is charged by 210.192 RSMo to organize the panels. The local panels are then responsible for reviewing all child fatalities in their county that meet the criteria for panel review. County panel members include:

- Prosecuting attorney;
- Medical examiner/coroner;
- Law enforcement;
- A representative of Children's Division (CD);
- A provider of public health services;
- A representative of the juvenile court; and
- A provider of emergency medical services.

Optional members from: drug/alcohol treatment, schools, mental health, domestic violence, dentists, and probation and parole may be added at the panel's discretion.

2. The general process of activating the panel is as follows:

- Coroners and medical examiners are required to immediately evaluate the deaths of all children under the age of eighteen who are eligible to receive a certificate of live birth to determine the necessity for a fatality review. This Includes children that are non-Missouri residents who die in Missouri and are issued a Missouri death certificate.
- If the coroner or medical examiner determines that the death of a child under the age of eighteen years does not meet the criteria for panel review, the Coroner/Medical Examiner Report (Form 1) will be completed, co-signed by the chairman of the local child fatality review panel, and the original forwarded to the regional child fatality coordinator. Form-1 data submitted to the regional child fatality coordinators is reviewed for completeness and linked to official vital statistics records centrally at the State Technical Assistance Team (STAT) Child Fatality Review Program Office in Jefferson City.
- In addition, when a child under the age of eighteen dies, who is eligible to receive a certificate of live birth a certified child death pathologist, in conjunction with the coroner or medical examiner, will determine the need for an autopsy. All children between the age of one week and one year who die in a sudden and unexplained manner, are to be autopsied by a certified child death pathologist.

- If the death meets the criteria for panel review, the coroner/medical examiner notifies the chairman of the CFRP, who then notifies the panel within 24 hours of a reviewable death.

Indications for a reviewable death involve one or more of the following:

- Sudden, unexplained death, age one week to one year;
- Death unexplained/undetermined manner;
- CD CA/N reports on the decedent or other persons in the residence;
- Decedent in CD custody;
- Possible inadequate supervision;
- Possible malnutrition or delay in seeking medical care;
- Possible suicide;
- Possible inflicted injury;
- Any firearm injury;
- Injury not witnessed by person in charge at time of injury;
- Death due to confinement;
- Suspicious/criminal activity
- Drowning;
- Suffocation or strangulation;
- Poisoning/chemical/drug exposure;
- Severe unexplained injury;
- Pedestrian bicycle/driveway injury;
- Motor vehicle injury
- Suspected sexual assault;
- Death due to any fire injury;
- Panel discretion; or

- Other suspicious findings (injuries such as electrocution, crush or fall).
- The CFRP reviews the fatality and each member carries out his/her specific mandates. (For example, CD will determine by a “preponderance of evidence” if the child died of abuse or neglect . Law enforcement will decide whether an investigation is warranted. The prosecutor will decide if someone should be arrested and charged with child endangerment, etc.) The main purpose of the panel review is to share information so that each person can more thoroughly carry out their agency's mandate. Within 45 days, the panel completes the Child Fatality Review Panel Report (Form 2) and forwards it to the regional coordinator. The regional coordinator then sends the form to STAT for review and linkage to official vital statistics records in Jefferson City.
- Although each discipline attending panel meetings have mandates specific to their fields, the panel function additionally affords the local community the opportunity to review events and circumstances surrounding deaths in an effort to better collaborate local preventive strategies.

3. Confidentiality and the sharing of information is essential during the review process.

A. Information Sharing

Senate Bills 757 and 602, signed into law July, 2000, amended the original CFRP legislation and expanded the mandate for the panel to review all deaths of children under the age of eighteen years, who are eligible to receive a certificate of live birth, which meet guidelines for review as set forth by the Department of Social Services (DSS). In addition, the panel may review at its own discretion any child death reported to it by the medical examiner or coroner, even if it does not meet the guidelines as set forth by the department. This cannot be accomplished unless all information known to panel participants is shared during the review of a death. It is each participant's legal obligation to do so. Participants are expected to fully access all information related to the victim, victim's family, and or persons who may have been involved in the death (i.e., baby-sitters, relatives, or the caretakers of the child at the time of death) and the circumstances surrounding the death. CD staff should share all child abuse and neglect information that they have on the victim(s), the caretaker of the victim at the time of the injury/death or other persons who may have been involved in the injury/death.

Except as provided in Section 630.167 RSMo, the coroner/medical examiner, public health representative, and/or CD representative, or a local CFRP may request copies of all records, medical and social, on a child who has died, from any hospital, physician, medical professional, mental health professional, or a Department of Mental Health facility.

Prior checks conducted by CANHU for child death review teams (medical examiners, coroner, etc.) Criminal Justice Agencies, and Juvenile Officers should include the release of more information than that which is given to other requesters. Information to be released is as follows:

Child Death Teams, Medical Examiners, Coroners

Preponderance of Evidence findings

- Court adjudicated findings
- Information on pending CA/N reports
- Open FCS, PS, and ZCAS cases
- Unable to locate findings
- All unsubstantiated findings
- All family assessment finding
- Non CA/N referrals

Criminal Justice Agencies and Juvenile Officers

- **Preponderance of Evidence** findings
- Court Adjudicated findings
- Information on pending investigations
- Open FCS, PS, and ZCAS cases
- Unable to locate findings
- All Unsubstantiated findings
- All family assessment findings

All Other Approved Requesters

- **Preponderance of Evidence** findings
- Court Adjudicated findings
- Information on pending investigations
- Open FCS, PS, and ZCAS cases
- Unable to locate findings

These records should then be disclosed by statute. Also, any legally recognized privileged communication, except that between attorney and client, shall not apply to situations involving the death of a child.

All records maintained by CD regarding hotline investigations, family assessments, referrals, mandated reporter contacts, non CA/N referrals, and Family-Centered Services, should be shared with the child fatality review panel. In addition the CD panel member or designee should search Family-Centered Service cases, income maintenance records, including Food Stamps, and all other records that may have pertinent information regarding the victim.

B. Confidentiality/Meeting Closure Policy

All CFRP meetings conducted, and all reports and records made and maintained by the CFRP, are confidential and shall not be open to the general public except for the annual report.

A proper panel review of a child's death requires a thorough examination of all relevant data, including historical information concerning the deceased child and his/her family. Much of this information is protected from disclosure by law, especially medical and child abuse/neglect information. Therefore, panel meetings are always closed to the public and cannot be lawfully conducted unless the public is excluded. RSMo 210.192 has broadened the reporting requirements of the CFRP Program to include the issuance of a final report. The final report is a summary of prevention conclusions and recommendations for each child death reviewed by a local CFRP. The Final Report is a public record and may be obtained by submitting a written request to: State Technical Assistance Team, Division of Legal Services, 2724 Merchants Drive, Jefferson City, Missouri, 65109.

Each panel should appoint a spokesperson. The spokesperson should confine his or public statements only to the fact that the panel met and that each panel member was charged to implement their own statutory mandates. No information about the case or panel discussions should be disclosed outside of the panel. All panel members who are asked to make a public statement should refer such inquiries to the panel spokesperson. Failure to observe this procedure may violate CD regulations, as well as confidentiality statutes that contain penalties.

No panel member is prohibited from making public statements about the general purpose or nature of the child fatality review process, however, no case-specific statements should be made. Panel members should be aware that the legislation which established the child fatality review panels provides official immunity to all panel participants. The CFRP panel and its members are advocates for the health and welfare of every child in their community, including the reasonable preservation of privacy for the child and family members.

C. Record Handling

Child Fatality Review Panel forms 1 and 2, generated by the Child Fatality Review Panel, will be forwarded to through the CFRP regional coordinator to STAT, where they will be linked with the Department of Health vital statistics data. If the Child Fatality Review Program Worksheet is used, it should be destroyed by the coroner/medical examiner upon completion of the Data Form 1. NO COPIES OF COMPLETED CFRP DATA FORMS 1 AND 2 SHOULD BE MAINTAINED IN LOCAL COUNTY CD FILES.

All information presented at the panel meeting should be considered lead information that needs to be confirmed by the individual discipline as true and factual before being included in any individual narratives report. While reports and documents may be shared and reviewed at panel meetings, these should not be copied and distributed to others. Outside of the CFRP review, agencies may share reports consistent with their policies and other legal restraints.

4. State Child Fatality Review Panel

The state CFRP, appointed by the director of the Department of Social Services (DSS), is composed of professionals from throughout the state from various agencies. The state CFRP will meet at least bi-annually shall:

- Review the findings of the county CFRP panels to determine the frequency and cause of child fatalities throughout the state;
- Identify the appropriateness and comprehensiveness of current statutes, policies, and procedures relevant to the management of fatal abuse/neglect cases;
- Review data collected by the DSS STAT to determine the accuracy of identification of fatally abused/neglected children;
- Review reports on the status of the operation of the county CFRP panels; and
- Recommend prevention strategies after reviewing statewide trends and actions suggested by local panels.

The state CFRP shall submit findings and recommendations to the director of DSS, the governor, the speaker of the House of Representatives, the president pro tempore of the senate, and the children's service commission, juvenile officers, and chairperson of the local CFRP panels. At minimum, the finding shall address the following issues:

The number of child fatalities reviewed by county panels;

Non-identifying characteristics for perpetrators

Non-identifying characteristics for deceased children;

The number of fatalities by cause(s) of death and whether death was attributable to child abuse/neglect;

Effectiveness of local panels; and

Systemic issues which need to be addressed through changes in policy, procedures, or statute.

5. The State Technical Assistance Team

The State Technical Assistance Team (STAT) shall develop and implement protocols per the evaluation and review of child fatalities, provide training, expertise, and assistance to the local CFRP on child fatalities and, if requested by the local CFRP, assist in the review and prosecution of specific child fatalities.

Upon receiving a request from a multidisciplinary team member to assist in an investigation, STAT must notify the local law enforcement agency, prosecutor, CD, a representative of the family courts, medical examiner, coroner, and juvenile officer, of the team's involvement. Where assistance has been requested by a local law enforcement agency, STAT investigators, certified as peace officers by the director of the Department of Public Safety, shall be deemed to be peace officers within the jurisdiction of the requesting law enforcement agency, while acting at

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the request of the law enforcement agency. The power of arrest of the STAT investigator acting as peace officer shall be limited to offenses involving child abuse and/or neglect, child sexual abuse, child exploitation or child fatality.

MEMORANDA HISTORY: CS03-26; CD04-79